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Abstract

There is often a focus on the negative aspects of residential care for older people. In the United Kingdom, there has been increasing media attention on abuse in these and other care settings and this has impacted upon public perceptions and subsequent government policy. Consequently, care staff are 'tarred with the same brush', yet narratives of their views have rarely been investigated. This undergraduate, qualitative, single case study aimed to investigate the views of staff and explore the implications for them and their practice. The views of 15 participants in a residential care home were obtained through interviews and a focus group. Although the findings reveal sensitivities to the negative portrayal of care roles, they also reveal positive responses through a willingness to change practice, a strengthening of care values and a reduction in risks. This study will be of interest

to those multi-disciplinary residential teams who care for older people as it uncovers a striking sense of guardianship amongst residential care staff, and a willingness to reflect on, and change, practice. The study endorses the value of small practitioner-led research as an illustration of how a residential care team consisting of managers and staff can strengthen its resolve against adverse media coverage and negative public perceptions. This study suggests that this will have positive implications for the health and safety of older people living in residential settings.

Key words: residential care; older people; media reports; elder abuse; residential carers; practitioner-led research; the reflective cycle.

Introduction

In the United Kingdom, about half of the estimated 1.3 million people working in adult social care are employed in residential settings, with most caring for older people (Skills for Care, 2015, p.30). There is often a focus within the media upon the negative aspects of this care with workers' stress and low morale affecting service quality and cost, and emotional detachment leading to the depersonalisation of residents (Thomas & Rose, 2009). These factors contribute towards high staff turnover (Mittal et al, 2009), prove costly in terms of recruitment, training and retention (SCIE, 2013), and affect the ability of staff to respond to difficult and challenging behaviours (Thomas & Rose, 2010).

Abuse in care has particularly received increasing media attention (Beach et al, 2016; Age UK, 2015). A high profile example of an undercover surveillance of abuse in a residential setting was televised at peak viewing time in 2014. The BBC Panorama team observed – incidents of abuse towards older residents, and additionally recounted a catalogue of previous incidents and complaints that had not been addressed over a six year period in a large residential setting in the United Kingdom (BBC, 2014a; Holt, 2014). However, the broadcast was not publically perceived in isolation. There had been previous BBC broadcasts highlighting abuse in the Winterbourne residential home for people with learning disabilities (BBC, 2012b) and on care of older people wards at Mid-Staffordshire NHS Trust (BBC, 2013c), resulting in a major public enquiry and government report (Department of Health, 2013). Most recently a Channel 4 programme revealed covert observations of abuse and neglect at specialist dementia care homes (Channel 4, 2017).

Inevitably, these events, programmes and subsequent public and official responses have stimulated debates regarding solutions for eliminating abuse in health and social care settings. These discussions have primarily focussed upon whistleblowing. In a recent study, Pohjanoksa et al (2017) found that 'wrong doing' occurred frequently, reporting that 52% of health care professionals observed inappropriate behaviours at least once a month. Care staff most often act when such abuse has been witnessed, but also when cuts to services have adversely impacted upon care, and when unethical working methods have been observed (Hedin & Mansson (2017). However, the '*Freedom to speak up review*' (Francis, 2015) emphasised that staff wanted to speak up but feared victimisation. Watson & O'Connor (2017) highlighted that staff who whistle blow often risk moral and personal distress, isolation and marginalisation by management. Care staff can therefore be

reluctant to whistle-blow (King and Hermodson, 2000), for fear of being blacklisted by colleagues (Perry, 1998; Jackson et al, 2010), and even dismissed from jobs (Gallagher, 2010).

Other solutions for detecting and preventing abuse have centred upon closed circuit television (CCTV) surveillance and the use of under-cover service users, those admitted under a pretence of requiring care. Kleebower (2016) discussed the potential for CCTV to improve care whilst others have raised concerns about issues of consent, privacy and dignity (Keogh, 2014). A study by Hall et al (2017) found that the use of CCTV did not always involve residents and their families in the decision to use this method of observation. The use of under-cover service users as been shown to improve the quality of care although there are dangers when people in these roles have a *'particular axe to grind'* (Sprinks, 2011). However, the use of this method has revealed poor care, inadequate diets and low levels of activities in residents (Duffin, 2011).

This media's interest, together with subsequent official responses and ongoing debates about solutions, can inadvertently suggest that widespread negative approaches to care exist amongst all staff (Stanley et al, 1999), implying pervasive complacency and aggression towards residents (Waite et al, 2009). Ash (2015, p25) argued that even though media reporting of abuse in residential settings attracted transient short-term attention, well-publicised accounts could have a long term bearing for those working within the sector. Smith (2014) described the damaging influence whereby hard work and devotion to physical and emotional toil by staff were ignored by the media; and Charpenter et al (2013) reported that sensationalistic media coverage conditioned family and residents' perceptions of abuse.

The lead researcher in the study reported here (YP) was a final year university undergraduate also employed as a health care assistant in a residential home for older people. There were anecdotal suggestions within that setting that carers were being unfairly 'tarred with the same brush', and it was clear in subsequent discussions between YP and her research supervisor (PMcD, a health psychologist) that many staff felt unappreciated, frustrated and unheard. These off-the-record narratives concerning staff feelings, perceptions of care roles, and views on potential solutions have not been reported in the academic literature and this provided the purpose for this work. The team feel that this study will be of interest to all those working within the multi-disciplinary dimensions of care for older people.

Aim

The aim of the study was to explore the views and perceptions of residential care staff on media coverage of abuse, and to assess the implications for them and for their practice.

Methods

A qualitative, single case study methodology was adopted for two reasons: firstly, access to only one residential care home was feasible within the timeframe allowed for an undergraduate study; secondly, there was an opportunity to collect in-depth data from a group who can sometimes feel isolated and rarely heard (Hannon & Clift 2010, p62). It was felt that a series of semi-structured interviews, conducted at differing times of the day and night, would enable an exploration of views held by a range of staff working in varying roles across the care setting. The study team also believed that interaction between staff would facilitate a deeper discussion of the issues (McLafferty 2004, p187). A focus group was

therefore conducted alongside individual interviews to ensure that participants were able to share and respond to the comments of other people's ideas and perceptions (Litosseliti, 1993, p1). The research team felt that the focus group would further strengthen and validate interview data. Thematic analysis of data was chosen as a method of analysis as it was considered most appropriate for an undergraduate, novice researcher (Braun & Clarke, 2006).

Setting and ethical considerations

The setting for the study was a residential care home in the West Midlands, United Kingdom, comprising of 64 beds and providing residential, dementia and respite care for older people. As stated, YP was a health care assistant in the home at the time of the study and, consequently, the study team paid particular attention to the ethical implications that this might entail. First, whilst planning the study, the team were conscious of the time and shift constraints that are common in such settings, and were particularly sympathetic to periods when the home was at its busiest. Secondly, discussions with managers regarding the arrangements for consent, confidentiality, potential disclosure, and staff welfare were carried out by YP with supervision from PMcD. Finally, prior to commencement a study proposal incorporating these considerations was reviewed and approved by the residential home's senior management team, and ethical approval was further obtained from Newman University, Birmingham. Once approved, a series of leaflets and internal communications informed staff and managers of the forthcoming study.

Participants

A total of 15 members of day and night shift staff participated in the study. Ten were interviewed (9 qualified and 1 non-qualified), whilst 5 (2 managers, 2 qualified and 1 non-qualified staff) contributed to the focus group. All managers and qualified staff had previous care experience, whilst the 2 unqualified staff not so.

Interviews and focus group

The semi-structured interviews lasted between 1 and 1 ½ hours and were conducted by YP in a private room within the home. Participants were provided with both verbal and written information about the study and written informed consent was obtained. During the interviews contemporaneous notes were made by YP. Interviews were not recorded due to reservations expressed by participants. The focus group was facilitated by YP and took 2 ½ hours. Participants agreed to record the session and a note taker was also present. An information leaflet was distributed and written informed consent was obtained prior to the start of the focus group. The focus group commenced with a showing of the Panorama (BBC, 2014) programme.

In both the interviews and focus group, 12 questions were used to assist YP to explore three domains focussing upon feelings, roles, and potential solutions (Table 1).

Table 1: Questions used in interviews and focus group

Findings

Analysis of interviews and the focus group revealed two themes:

Changing public views of residential carers

Participants felt that they had become subject to increased external scrutiny following high profile scandals. The implications of this were conveyed in terms of the public perceptions and appreciation of them as residential carers:

All the same

First, it was felt that perceptions of residential carers had changed and there was a sense amongst care staff that they had been *"tarred with the same brush",* that the public thought *"every care home is the same"*, and that one occurrence of abuse had brought *"too much negativity".* Clearly it was felt that media-led reports of abuse had a "*knock on effect"* with participants stating:

Box1

Undervalued

Secondly, there was a sense that the appreciation of residential care roles had diminished. Even though some felt that *"carers were valued"* the recognition of the psychological and physical demands of these roles had been tarnished by media reports of abuse:

Box2

Guardians to the vulnerable

Even though participants described *"feelings of shock"* and *"complete disgust"* at reports of abuse and the impact they had had upon morale, their strongest response to them had triggered a *"sense of responsibility"* and reinforced their self-perceived role as guardians to the vulnerable. This was expressed in a number of ways:

Changing practice

Firstly, well publicised stories of abuse in residential settings had changed safeguarding practice. Staff were *"more aware of what is going on around them"*, more likely to ensure that other members of staff were "*following policies and procedures*", and described an increased need to observe the practice of others:

Box3

Participants described how their roles had expanded and adapted to the *"added pressures on care staff"*:

Box4

Shared values

Secondly, participants' descriptions of this role reflected shared values that underpinned practice, defining safeguarding in terms of "*duty", "privilege"*, and a *"desire to protect"*. For example, one participant stated:

Box5

This was further strengthened by ethical concerns regarding potential safeguarding solutions and subsequent changes to practice. For example, although there was a general acceptance of CCTV, staff not only expressed fears about potential invasions of privacy and confidentiality for residents but they also required assurances that consent from them would be obtained:

Box6

Reducing risk

Thirdly, participants were receptive to potential solutions that would reduce risk within their practice. For example, most were comfortable with the introduction of closed circuit television (CCTV) as it not only protected residents but also members of staff at times of accusation:

Box7

There was also an appreciation of whistleblowing as a means of safeguarding residents. Participants emphasised their duty to report and protect when *"they have concerns in terms of any abuse or a resident's safety"*, and considered this as *"the main priority for all care staff* [and] *go beyond the call of duty to make sure the resident is safe and happy"*:

Box8

Participants were also acutely aware of the associated risks to themselves. For example, in regards to whistleblowing:

Box9

The use of under-cover residents was interpreted in terms of *"advocacy"* and seen as *"unobtrusive"*, and facilitating the *"resident's voice"*:

Box10

In this light, participants further emphasised the importance of *"strict guidelines"*, *"induction"* and future *"staff training"* that was *"delivered properly and put into practice"* so that *"management* [could] *highlight poor practice and help identify the wrong and right ways of working".*

Discussion

The findings of this study have shown that residential care workers are sensitive to the negative stereotypes and undervaluing of their roles following media reports of abuse. However, the study reveals that residential carers can also respond positively to these accounts of mistreatment through changing practice, strengthening care values and

reducing risks. These findings raise three key issues that have implications for those in residential care practice.

First, this study uncovers a striking sense of guardianship amongst residential care staff that is both positive and robust. Previous evaluations of media reports of abuse have tended to report the negative implications for care staff following media reports of abuse. For example, research by Stanley et al (1999), Waite et al (2003) and Ash (2015) described the adverse effects in terms of negative approaches to care, staff aggression and long–term unfavourable attitudes amongst staff. In many ways these consequences have been a good 'fit' for the increasingly common perception of a care sector in stagnation and crisis (Thomas & Rose, 2009; Mittal, 2009; SCIE, 2013). Other high profile examples of abuse and scandals in other parts of the United Kingdom health and social care sector have augmented this opinion across the public domain and amongst professional groups. However, although this study reports individual feelings of frustration and disappointment amongst staff, these are clearly not the only facets that define them as carers. We suggest that those who own, manage, commission, inspect and visit residential care settings are mindful of this and appreciate that staff are not passive agents, are not necessarily set in their ways, are able to adapt to new challenges, and can embrace new ways of working.

Secondly, this study indicates that residential care staff, if given the opportunity, will reflect on practice and act accordingly. This small undergraduate research study inadvertently stumbled across an exemplar of reflective practice. Although it was not the intention of the research team, the study suggests that staff participation in the study could be likened to the Gibbs (1988) reflective cycle. Jones & Cookson (2000) stated that reflective practice was

not instinctive and for it to occur –structure is required. This study implies that it can be both. The research was conducted by an unqualified member of staff whose study offered an opening for staff to have a voice through interviews and a focus group, and to intuitively reflect upon what the issues meant to themselves, their residents and their place of work. It is certain that once they had expressed their feelings, and had evaluated and analysed events, they then clearly described what actions had been taken in their response to media reports of abuse.

Finally, this study illustrates the value of carer-led, small scale research in practice settings. Lehmann et al (2004) argued that "collaborative inquiry is a powerful tool to develop reflective capacity among health workers", and Moffatt et al (2005) outlined a process for community practice research as a reflective process. Walker & Poland (2000) reported on an action research cycle that provided a process of generating information which facilitated positive and cost-effective changes to practice. The research reported in this paper was not instigated 'from above' and was developed and led by a health care assistant who had been taught research skills. Perhaps this in itself erased fears of officialdom and diminished concerns that may be present in 'top-down' audits and service evaluations. It seemed to the research team that the exercise had been perceived by participating staff as both valuable and enabling. The team also felt that, although the participation of managers may have influenced findings, it was clear that a staff versus manager dimension was not present. In contrast, the private home had in fact opened itself up to the research in an effort to strengthen its resolve against adverse media coverage and changing public perceptions.

Limitations to this study

This research project was undertaken independently by YP, an undergraduate and novice researcher, and supported within a regulated level of supervision from second author PMcD. There is therefore full recognition of the potential weaknesses of a study shaped by limited resource and a specified timeframe, and by the additional demands made during the final year of undergraduate study.

The research team have already noted the ethical connotations of a care worker-researcher collecting data in their own workplace, and were further cognisant of the methodological implications of this in terms of the credibility of the methods and data collected. The team were aware of the potential biases within the convenience sample and, in particular, the influence of both the presence and views of participating managers upon the contributions of other participants. The authors were mindful that the study would only report the views of staff from one residential home, and were further aware that the study would have been enhanced by the involvement of residents in both the design and data collection stages.

Despite these limitations, the team feel that the results of this undergraduate study are worthwhile and add to the literature on staff responses to accusations of abuse in care. The team would further hope that this study in itself will inspire other novice health and social care researchers to conduct and publish studies that would influence not only their practice, but also the practice of those around them and across the health and social care sector.

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Roles	*Do you think programmes like Panorama affect your role as a carer?* *What are your thoughts on your current care role?* *What are your thoughts about care as a domesticated role?* *Do staff levels have an impact and influence on how you feel?*
Feelings	*Can you explain how you feel about programmes on elderly abuse, such as the Panorama programme?* *Do you consider your work to be valued by the public?* *Have your views on your caring role changed?* *What attracted you to care?*
Solutions	*What are your thoughts on the installation of CCTV systems?* *What are your thoughts on under-cover residents?* *What are your views on whistleblowing?* *Do you think training helps?*

Table 1: Questions used in interviews and focus group

[Events have] *"changed people's views about me and my job"* (participant 5)

"don't let one mistake define us all" (participant 2)

Box 1

"All of us are dedicated in our work [……] *but this is over-looked by the media" (participant 2)*

"being a care worker in the UK is a very under-valued job" (participant 7)

"*family members gain information from the programme giving them ammunition"*

(participant 10)

[the] *"representation of care has changed in so many ways"* (participant 1)

Box 2

"yes, it makes you constantly aware of abuse that can go on inside any care home, and makes you cautious of other staff, to make sure they are not mistreating any residents"

(participant 5)

Box 3

"I tend to be more aware of the way I approach, speak to or interact with my residents"

(participant 10)

"My views on care have changed and I have become more and more [involved] *with paperwork than hands on* [care]" (participant 3)

"[I now] *undertake other roles within the organisation. The current environment requires learning to keep up with change"* (participant 12)

Box 4

"I keep in my mind that this is their home, and it's a privilege to look after those that need assistance" (participant 6)

Box 5

"as long as there were certain guidelines to the use of the system……..as long as consent was acquired" (participant 8)

"privacy and dignity should be respected" (participant 1)

"under-cover residents shouldn't be happening, the things care staff talk about and deal with should be kept confidential and not publicised to anyone other than the resident involved or care staff in the home" (participant 6)

Box 6

"I don't have a problem with the installation of CCTV in care settings, I feel that CCTV can be of benefit in cases of accusation of neglect or abuse" (participant 1)

Box 7

"I am a strong believer in whistleblowing and have done this myself with work colleagues in my previous employment as a carer" (participant 3)

Box 8

"It is a shame that the person who whistle blows can be given a hard time…. Just lately this has been big news and the media highlight how whistleblowers are treated and lose their jobs" (participant 4)

"those who don't whistle blow are seen as bad" [participant 5]

Box 9

"I think under-cover residents are a good idea, they are the eyes and ears of the residents with a view to protect those who may not be able to speak up for themselves" (participant 7)

Box 10